DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NX3M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245045**
2.STATE VENDOR OR MEDICAID NO.
(L2) **695045102**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE HEALTH CARE CENTER**
(L4) **512 SKYLINE BOULEVARD**
(L5) **CLOQUET, MN** (L6) **55720**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/25/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 09/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/06/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
08/29/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245045

October 6, 2016

Mr. Jeffrey Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

Dear Mr. Brown:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 23, 2016 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 15, 2016

Mr. Jeffrey Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

RE: Project Number S5045026

Dear Mr. Brown:

On July 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 12, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 14, 2016, effective August 23, 2016 and therefore remedies outlined in our letter to you dated July 28, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245045		8/25/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 08/17/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 08/12/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 08/23/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) TA/mm	DATE 09/15/2016	SIGNATURE OF SURVEYOR 29433	DATE 09/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245045 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	9/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	08/03/2016	LSC K0029	08/01/2016	LSC K0052	08/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0056	08/23/2016	LSC K0062	08/23/2016	LSC K0104	08/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0144	08/23/2016	LSC K0154	07/20/2016	LSC K0155	07/20/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	09/15/2016	27200	09/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245045 Y1	A. Building 02 - DINING/ACTIVITY B. Wing Y2	9/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	08/23/2016	LSC K0062	08/23/2016	LSC K0104	08/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0144	08/23/2016	LSC K0154	07/20/2016	LSC K0155	07/20/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	09/16/2016	27200	09/12/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NX3M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245045**

2.STATE VENDOR OR MEDICAID NO.
(L2) **695045102**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE HEALTH CARE CENTER**
(L4) **512 SKYLINE BOULEVARD**
(L5) **CLOQUET, MN** (L6) **55720**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/14/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kahtie Killoran, HFE NEII 08/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/29/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 28, 2016

Mr. Jeff Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

RE: Project Number S5045026

Dear Mr. Brown:

On July 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 23, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

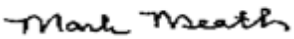
Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1/2 sheet pans were free of baked-on debris and a canister of slivered almonds was stored in a sanitary manner. This had the potential to affect all 43 residents in the facility. On 7/11/16, at 12:06 p.m. a canister of slivered	F 371	Sunnyside Health Care Center does procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and serve food under sanitary conditions for all residents. This deficiency was noted on sheet pans that had residual baked-on debris as well as a	8/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/05/2016

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F 371	Continued From page 1 almonds was observed with a plastic cup used by staff to "scoop" the almonds out of the canister, stored inside it. The nutrition services manager (NSM)-C confirmed that the plastic cup should not be stored in the canister of almonds. On 7/11/16, at approximately 12:15 p.m. four 1/2 sheet pans were observed to have dark, baked-on debris on their inside edges and bottoms. On 7/13/16, at 11:18 a.m. a plastic cup was again observed to be in the canister of slivered almonds. NSM-C confirmed the scoop was in the canister and that she would remove the canister. On 7/13/16, at 11:19 a.m. 6 1/2 sheets were observed to have baked on food debris on their inside edges sides and bottoms. The debris could not be scraped off. NSM-C stated parchment paper was sometimes used as a pan liner, but it is each cook's preference, not a kitchen protocol. On 7/14/16, at 3:31 p.m. NSM-C stated the 1/2 sheets were specially cleaned. The 1/2 sheets were observed to still have baked on debris. NSM-C stated the 1/2 sheets were used several different ways: they were used to cook meat; they were used to hold desserts in a freezer or cooler; and they were also used as drip pans (placed under the grill to catch juice from cooking meat). NSM-C thought that was why they were soiled. NSM-C confirmed that the debris did not come off and all residents of the nursing home could potentially be served food that had been cooked on the 1/2 sheets. The facility policy Use and Sanitation of Dietary Equipment and Supplies dated 9/20/15, directed	F 371	"scooping" utensil that was left in a canister of almonds. An Assessment was performed on all equipment/pans in the kitchen; all sheet pans and/or equipment with un-removable burnt on grease/food particles and/or have become dented, cracked, or damaged were removed from service immediately and given to the Supervisor for proper disposal. Policy NUT-0007- Use of Three Compartment Sink for Cleaning and Sanitizing Food Service Equipment was reviewed and updated on 07/19/2016. Measures to correct the deficient practice are as follows: All Nutrition Services staff and Supervisors re-educated on the Use of Three Compartment Sink for Cleaning and Sanitizing Food Service Equipment. The evening Supervisor will be responsible for checking all pots and pans daily, and removing any equipment that exhibits debris or damage, and completing the equipment check log. The Department Director is responsible for reviewing the equipment check log and reporting findings/results at the department meetings on a monthly basis and at the long term care QA meeting quarterly. Utensils are never stored in the same container as the food. All utensils used in preparation or portioning are returned to the dish-room for proper cleaning. All	

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F 371	Continued From page 2 employees to notify the dietary manager of all damaged or defective equipment.	F 371	canisters were checked to ensure no utensils were in the same container. Sanitary Preparation and Storage of Prepared Food Policy and Procedure was reviewed and updated on 07/20/2016. Measures to correct the deficient practice are as follows: All Nutrition Services staff and Supervisors will be educated on the proper procedure per policy. The evening Supervisor is responsible for checking the store rooms daily to assure no utensils are stored inside the containers as the food. In addition to this, the Supervisor will also be responsible for completing the Food Storage Check Log. The Department Director is responsible for reviewing the check log and following-up as needed to ensure on-going compliance. The results of this log will be brought to the monthly department meetings as well as the long term care QA meeting on a quarterly basis.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		8/12/16

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F 441	Continued From page 3 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene was performed during and after resident cares for 1 of 4 residents (R20) observed during cares. In addition, scissors were not cleaned or replaced after becoming contaminated for 1 of 1 (R55) residents observed during a dressing change.	F 441	SHCC does provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection for all residents. This deficiency was noted on 1 of 4 residents in relation to hand hygiene. NA-A was directly involved with this deficiency. A coaching was conducted	

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F 441	Continued From page 4 Findings include: R20's Cumulative Diagnosis List dated 1/22/16, indicated R20's diagnoses included congestive heart failure, pleural effusion, atrial fibrillation and venous stasis lung mass. The significant change Minimum Data Set (MDS) dated 4/28/16, indicated R20 had no cognitive impairment. R20 needed extensive assistance of one staff with all activities of daily living (ADL). On 7/13/16, at 9:05 a.m. nursing assistant (NA)-A was assisting R20 with morning cares. The upper portion of R20's cares had already been completed. NA-A washed her hands and donned gloves. R20 stood up from the toilet, NA-A washed R20's peri area and then changed her gloves. NA-A did not wash or sanitize her hands. NA-A then washed R20's buttocks, removed her gloves, pulled up R20's incontinent product and pants. NA-A did not wash or sanitize her hands. NA-A retrieved the walker and R20 ambulated to the recliner. NA-A combed R20's hair, attached the call light to the recliner, moved and set up the over bed table. NA-A retrieved R20's glasses from the bathroom and applied the glasses to R20's face. NA-A moved R20's walker and donned gloves. NA-A did not wash or sanitize her hands. NA-A gathered the bags of trash and soiled linens and put R20's bed clothes in the closet. NA-A removed the gloves, placed both hands on the arm of the recliner, moved the tray table, picked up the soiled linen and trash bags and exited R20's room. NA-A did not wash or sanitize her hands. NA-A walked to the soiled utility room, opened the door with the door knob, put the trash and soiled lined bags in the bins and then washed her hands.	F 441	with NA-A in regards to proper hand washing during resident care and the policy was reviewed. Per Infection Control: Hand Hygiene policy and procedure, hand hygiene will be performed before and after removing any type of glove used in patient care. Audits will be conducted daily x1 week, weekly x1, monthly x1, and randomly to ensure ongoing compliance by employee. These audits will be done by an RN. Measures to correct the deficient practice are as follows: All staff (RN□s, LPN□s, NA/R□s) will be re-educated with the hand hygiene policy and procedure. Continued monitoring will be done by a QA tool and completed by an RN. Along with on-going monitoring indicated for NA-A as above, random audits will be conducted to ensure all staff is within compliance. The random audits will be done for five employees on a weekly basis until all employees have been checked to ensure facility wide compliance. The correction will be monitored by the Nurse Managers and Director of Nurses to ensure compliance. Issues will be brought to the weekly resident care meeting with results of audits by the Director of Nurses. Results will be discussed and provided at the quarterly LTC QA meeting. The Director of Nurses will be responsible.	

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F 441	Continued From page 5 On 7/13/16, at 9:20 a.m. NA-A stated that was the way she usually did cares. NA-A verified she washed her hands in the beginning and did not wash or sanitize her hands between glove changes or prior to exiting R20's room. NA-A stated she should have washed her hands before exiting the room. On 7/14/16, at 12:45 p.m. the director of nursing (DON) stated staff should be washing or sanitizing their hands between glove changes as able and prior to exiting the resident's room. The DON stated she had talked to staff about hand hygiene constantly and they were all aware. The facility's Hand Hygiene policy reviewed and revised on 6/18/15, indicated hand hygiene was to be done before and after resident contact and before and after removing any type of glove used in resident cares. R55's Summary List identified diagnoses that included non-pressure chronic ulcer on the right foot. R55's care plan dated 6/30/16, indicated R55 was admitted with posterior calf ulcers and right foot ulcers. The physician's orders signed 7/6/16, directed Santyl to posterior calf wound twice daily, and bilateral Unna boots. On 7/13/16, at 9:24 a.m. registered nurse (RN)-B and RN-C were observed preparing to change dressings on R55's lower legs. RN-B stated she would remove the dressings with a blunt scissors. With the blunt scissors, RN-B cut away the Unna-FLEX dressing (compression dressing) and the underlying Kerlix dressing from R55's left leg, starting near the knee, down to her ankle, and then on top of her foot until both layers of	F 441	SHCC does provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection for all residents. This deficiency was noted on 1 of 1 resident in relation to improper cleaning/sanitizing of equipment during a dressing change. A coaching was conducted for RN-B and RN-C in regards to dressing changes; ensuring that scissors or any type of equipment is sanitized before and after use. Measures to correct the deficient practice are as follows: All Nursing staff will be re-educated on Infection Control practices in relation to wound care. Monitoring will be completed by a QA tool and done by a Nurse Manager or Director of Nurses to ensure all Nursing staff is within compliance. Audits will be done weekly x4, monthly x2, and random as needed. The Wound Care policy and procedure was updated and revised. The correction will be monitored by RN□s and the Director of Nurses to ensure compliance. Issues will be brought to the weekly resident care meeting and monthly Nurses meeting with results of audits by the Director of Nurses.	

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F 441	Continued From page 6 dressings were removed. This was repeated on R55's right leg. As she removed the dressings, RN-B placed them in the garbage on the floor beneath her. RN-B set the scissors down on the towel that was below R55's left leg. The scissors remained on the towel while RN-B and RN-C washed R55's left leg, cleansed the wound on her posterior calf, applied Santyl (an ointment that helps cleanse wounds), and reapplied new Kerlix. RN-C set the scissors down on R55's incontinence pad while she worked to loosen the end of the Unna-FLEX. RN-C then applied the Unna-FLEX dressing to R55's left leg. When finished with R55's left leg, RN-C and RN-B set up a dry washcloth near R55's right leg and placed supplies, including the blunt scissors, on the washcloth and a fresh towel under R55's right leg. RN-C washed R55's right leg, used saline to wash her wound, and applied the Santyl. During this time, the scissors were on R55's blanket, not the clean washcloth. RN-B left the room to get tape and additional Kerlix. Upon her return, RN-B picked up the scissors from R55's blanket and used the scissors to cut tape, which RN-C applied to better hold the Unna-FLEX on R55's left leg. RN-C applied gauze to an additional wound on R55's 4th toe on her right foot. RN-B used the scissors to cut tape that RN-C then used to hold the dressing onto R55's skin. On 7/13/16, at 10:08 a.m., RN-B stated that scissors are sanitized after dressing changes by soaking in alcohol in the utility room. In an interview on 7/14/15, at approximately 2:00	F 441	Results will be discussed and provided at the quarterly LTC QA meeting and action taken as necessary. The Director of Nurses will be responsible.	

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F 441	Continued From page 7 p.m., the director of nursing (DON) stated she did not think it was a concern that the scissors did not remain in the clean field, as they were not used against R55's skin after they were off the clean field.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 10 resident rooms (rooms 254, 260, 262, 264, 265, 267, 270, 271, 272) were well maintained, 3 resident bathroom floors (rooms 269, 270, 271) were clean, and 1 resident wheelchair was in good repair. Findings include: On 7/11/16, at approximately 6:00 p.m., the bathroom floors of rooms 256, 264, and 269 were observed to have a build up of dust and debris in the corners behind the door and under the sink On 7/14/16, at 9:58 a.m. an environmental tour was conducted with the director of building and grounds (DBG) and the environmental services supervisor (ESS). The following rooms were identified in need of repair:	F 465	Sunnyside Health Care Center does provide a safe, functional, sanitary, and comfortable environment for all residents, staff and the public. The deficiency was noted on 10 resident rooms, 3 resident bathroom floors, and 1 resident wheel chair. Resident rooms 254, 260, 262, 264, 265, 267, 270, 271, 272 will be inspected thoroughly to ensure the all doors are free from chipped, rough or sharp edges. Sticky adhesive will also be removed. Scrapes and gouges on doors will be patched. Where appropriate, kick plates or protective edge/corner guards of high quality will be installed. All room and bathroom door frames will be inspected, cleaned, patched and painted. All room molding will be inspected and replaced as appropriate.	8/23/16

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F 465	Continued From page 8 Room 254 had long scrapes along the wall. Room 260 had scrapes on two walls. Room 262's door had chipped edges, with sharp, exposed rough wood, approximately 3 feet long. Room 264's door had several chipped areas on the inner and outer edges, approximately 3 feet up from the floor. The door also had plastic covering that was lifted away from the lower outer edge and broken. In addition, the outside of the door had 5 areas of sticky white tape adhesive. The bathroom door, had several chipped areas on the inner and outer edges, approximately 2 feet up from the floor. The bathroom door frame had paint scraped off, approximately 2 feet up from the floor. Room 265's base board had a 2 inch by 2 inch piece missing in the corner between the entry door and the bathroom door, exposing sheetrock. Room 267's room door was chipped and loose on the inside bottom, approximately 8 inches long. The bathroom door had chips in 3 or 4 areas approximately 3 inches by 1/2 inch. The inner edge of the door also had a 4 inch chipped area. The molding in the corner between the room door and the bathroom had a piece missing, approximately 4 inches by 4 inches, exposing sheet rock. The foot pedal for the bathroom sprayer was tied up with a piece of plastic. Room 269's bathroom door frame was scraped and peeling. Room 270's and room 271's entry and bathroom	F 465	Resident bathroom floors (256, 264, 269, 270, 271) will be free of dust and debris. Each resident bathroom floor will be thoroughly cleaned. R20's wheelchair has been removed from the floor, and replaced with a new chair which is free from any cracks, pieces missing, or damage. Measures to correct the deficient practice are as follows: A checklist of all items (doors, door frames, molding, walls, and floors) has been developed and will be used to conduct weekly room checks. Weekly audits of five additional rooms will be conducted. Once all resident rooms have been audited, repaired, approved, audits will be done monthly x 3months. All resident's wheelchairs will be assessed monthly by Director of Nurses and Occupational Therapy to ensure functional safe equipment is in place. Findings will be documented on a audit checklist and forwarded to Responsible persons listed below. Quarterly reviews at QA/QI meeting will determine action taken. Responsible persons: Director Building & Grounds, and Environmental Services Supervisor	

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F 465	Continued From page 9 doors were scraped and chipped. Room 272's entrance door had multiple scuffs on the lower half. The bathroom door was chipped on the outer edge. R20's wheelchair back had several cracks areas, the left arm rest cover had a small v-shaped crack and 3 small areas with pieces missing. The right arm rest cover had a piece missing approximately 1/2 inch by 1/2 inch. The DSM stated they do not routinely check wheelchairs, but if a nursing assistant or housekeeper notices, they will repair or replace parts of a wheelchair. On 7/14/16, at approximately 10:00 a.m. the DBG stated they were not aware of these issues and the do not have a policy on room maintenance. The DBG provided an email dated 5/12/16, explaining the process of requesting work to be completed, but they do have an official policy. On 7/14/16, at approximately 10:15 a.m. the ESM stated their policy is to mop the bathroom floors daily, but perhaps the grout needs to be deep cleaned or replaced. The facility Daily SHCC Resident Room Cleaning policy dated 12/21/15, was provided. The policy directed daily, each resident room and restroom will be cleaned by housekeeping staff.	F 465		

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	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/14/2016**

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SUNNYSIDE HEALTH CARE CENTER	**512 SKYLINE BOULEVARD CLOQUET, MN 55720**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Sunnyside Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	**512 SKYLINE BOULEVARD CLOQUET, MN 55720**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Sunnyside Care Center, is a 3-story building with no basement. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968 the second floor was added, also Type II(111) construction. In 2000 dining rooms were constructed on floors one and two of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. This skilled nursing home is not 2 hour fire rated separated from the attached hospital, and the hospital was also inspected. The nursing home beds are all located on the 2 story of the building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection	K 000		

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	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/14/2016**

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K 000	Continued From page 2 that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 44 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA Life Safety Code 101 2000 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 10 of 43 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:00 AM to 4:00 PM on 07/14/2016, observation revealed that there is a penetration found around conduit and wires that are passing through the 1 hour smoke barrier above the ceiling tiles in the smoke barrier wall located by resident room 269 in the North Hall. This deficient condition was verified by a Maintenance Supervisor.	K 025	Penetration found around conduit and wires that pass through the 1 hour smoke barrier above the ceiling tiles in the smoke barrier wall locating in resident room 269 has been sealed. Person responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Services has verified completion.	8/3/16

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K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities of residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/16, observation revealed that the door to the ground floor soiled linen chute room did not fully close and positively latch into the frame. This deficient condition was verified by a Maintenance Supervisor.	K 029	Door to ground floor soiled linen chute room has been repaired to fully close and positively latch into the frame. Person responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Services has verified completion, and will audit monthly x 12. Findings will be discussed at quarterly QA/QI meeting.	8/1/16
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall	K 052		8/23/16

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K 052	Continued From page 4 be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/16, observations revealed that during the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 2 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by a Maintenance Supervisor.	K 052	Facility will verify and document 12 monthly tests of the digital alarm communicator transmitter (DACT). Person Responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Service will audit testing monthly x 12 months. Findings to be reported at quarterly QA/QI meeting.	
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an	K 056		8/23/16

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K 056	Continued From page 5 approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, observations reveled that there is a fire sprinkler head that is part of an abandoned domestic sprinkler system that is not tied to the fire alarm that is located in the 2nd floor janitors closet that is located by the nurses station that is installed within 24 inches of a fire sprinkler head that is part of the facility's complete fire sprinkler system that is tied to the facility's fire alarm. This deficient condition was verified by a Maintenance Supervisor.	K 056	Abandoned domestic sprinkler system that is not tied to the fire alarm system located on the 2nd floor janitors closet near nursing station will be removed with ceiling opening properly repaired by authorized sprinkler system contractor. Person responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & ancillary Services will audit to verify completion.	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		8/23/16

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	245045	A. BUILDING 01 - MAIN BUILDING B. WING _____	07/14/2016

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K 062 SS=D	Continued From page 6 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, a review of documentation and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide documentation for 2 of 4 quarterly fire sprinkler flow test verifying that they have been completed. This deficient condition was verified by a Maintenance Supervisor.	K 062	Director of Building & Grounds contacted sprinkler testing contractor on 8/1/2016, to place facility on a quarterly and annual flow testing schedule. Quarterly & annual sprinkler flow tests results will be documented. Person Responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Services will conduct quarterly audits of sprinkler flow testing to verify completion and documentation x 12 months.	
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are	K 104		8/23/16

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K 104	Continued From page 7 not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 34 of 34 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 AM to 4:00 PM on 07/14/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years. This deficient condition was verified by a Maintenance Supervisor.	K 104	Facility will complete smoke damper testing and inspection at least every four years with documentation to verify testing and inspection. Director of Building & Grounds is searching for reputable contractor to perform smoke damper testing. Responsible person: Paul Charon, Director Building and Grounds. Jeff Brown, VP of LTC & Ancillary Services will audit for completion and continued compliance.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be	K 144		8/23/16

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K 144	Continued From page 8 in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility in the event of an emergency. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, it was revealed during the review of the facility's emergency generator testing and maintenance logs that the following deficient conditions were found: 1. The facility could not provide 42 of 52 weekly emergency generator inspection reports at the time of the inspection. 2. Due to the extent of physical damage to one page of the emergency generator inspection log the information provided in that page of the emergency generator documentation was incomplete for 3 of 12 monthly inspections of the emergency generator. This deficient condition was verified by a Maintenance Supervisor.	K 144	1. Facility Engineers will conduct weekly generator testing & maintenance. Documentation will include date, time, name of person conducting test and the maintenance required. Person responsible: Paul Charon, Director Building & Grounds. Jeff Brown will audit weekly documentation of generator testing and Maintenance monthly x 12. 2. Facility Engineers will conduct and document monthly emergency generator inspections. Documentation will include date, time, name of person conducting inspection & results of inspection. Responsible person: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Services will audit inspection documentation monthly x 12.	
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is	K 154		7/20/16

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K 154	Continued From page 9 out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor.	K 154	Facility has updated the Fire Protection System Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008 on 07/20/2016. The policy now includes the current State Fire Marshall s contact information in the event that fire sprinkler is out of service for more than 4 hours in a 24 hour day. Person responsible: Paul Charon, Director Building & Grounds Jeff Brown, VP of LTC & Ancillary Services has verified Fire Protection Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008, is complete and acceptable as of August 3, 2016.	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is	K 155		7/20/16

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K 155	Continued From page 10 provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor.	K 155	Facility has updated the Fire Protection System Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008 on 07/20/2016. The policy now includes the current State Fire Marshall s contact information in the event that fire sprinkler is out of service for more than 4 hours in a 24 hour day. Person responsible: Paul Charon, Director Building & Grounds Jeff Brown, VP of LTC & Ancillary Services has verified Fire Protection Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008, is complete and acceptable as of August 3, 2016.	

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	245045	A. BUILDING **02 - DINING/ACTIVITY** B. WING _____	**07/14/2016**

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K 000	INITIAL COMMENTS Building #2 "New" Nursing Home Dining Room Addition FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Community Memorial Hospital-Sunnyside NH (bldg. #2) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING **02 - DINING/ACTIVITY** B. WING _____	**07/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE HEALTH CARE CENTER	**512 SKYLINE BOULEVARD CLOQUET, MN 55720**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Community Memorial Hospital-Sunnyside NH,Building #2 (New Nursing Home) is a 3 story building with a full basement, Type I (332) construction. The building was constructed in 2012/2013 and is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in corridors, spaces open to the corridors and sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 43 at the time of the survey. NOTE: The Community Memorial Hospital-Sunnyside NH and is not 2 hour fire separated. Therefore, this inspection is broken	K 000		

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K 000	Continued From page 2 down into 2 distinctly different parts. i,.e, New Hospital, and New Nursing Home, Exist Hospital & Existing Nursing Home This is based on the different years of construction. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/16, observations revealed that during the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the	K 052	Facility will verify and document 12 monthly tests of the digital alarm communicator transmitter (DACT). Person Responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Service will audit testing monthly x 12 months. Findings to be reported at quarterly QA/QI meeting.	8/23/16

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K 052	Continued From page 3 facility failed to document and/or verify 2 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, a review of documentation and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide documentation for 2 of 4 quarterly fire sprinkler flow test verifying that they have been completed.	K 062	Director of Building & Grounds contacted sprinkler testing contractor on 8/1/2016, to place facility on a quarterly and annual flow testing schedule. Quarterly & annual sprinkler flow tests results will be documented. Person Responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Services will conduct quarterly audits of sprinkler flow testing to verify completion and documentation x 12 months.	8/23/16

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K 062	Continued From page 4 This deficient condition was verified by a Maintenance Supervisor.	K 062		
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 34 of 34 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 AM to 4:00 PM on 07/14/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years.	K 104	Facility will complete smoke damper testing and inspection at least every four years with documentation to verify testing and inspection. Director of Building & Grounds is searching for reputable contractor to perform smoke damper testing.	8/23/16

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K 104	Continued From page 5 This deficient condition was verified by a Maintenance Supervisor.	K 104		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility in the event of an emergency. Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, it was revealed during the review of the facility's emergency generator testing and maintenance logs that the following deficient conditions were found: 1. The facility could not provide 42 of 52 weekly emergency generator inspection reports at the time of the inspection. 2. Due to the extent of physical damage to one page of the emergency generator inspection log the information provided in that page of the emergency generator documentation was incomplete for 3 of 12 monthly inspections of the emergency generator.	K 144	1. Facility Engineers will conduct weekly generator testing & maintenance. Documentation will include date, time, name of person conducting test and the maintenance required. Person responsible: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Services will audit weekly documentation of generator testing and Maintenance monthly x 12. 2. Facility Engineers will conduct and document monthly emergency generator inspections. Documentation will include date, time, name of person conducting inspection & results of inspection. Responsible person: Paul Charon, Director Building & Grounds. Jeff Brown, VP of LTC & Ancillary Services will audit inspection documentation monthly x 12.	8/23/16

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K 144	Continued From page 6 This deficient condition was verified by a Maintenance Supervisor.	K 144		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1. This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated	K 154	Facility has updated the Fire Protection System Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008 on 07/20/2016. The policy now includes the current State Fire Marshall s contact information in the event that fire sprinkler is out of service for more than 4 hours in a 24 hour day. Person responsible: Paul Charon, Director Building & Grounds Jeff Brown, VP of LTC & Ancillary Services has verified Fire Protection Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008, is complete and acceptable as of August 3, 2016.	7/20/16

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K 154	Continued From page 7 This deficient condition was verified by a Maintenance Supervisor.	K 154		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 AM and 4:00 PM on 07/14/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor.	K 155	Facility has updated the Fire Protection System Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008 on 07/20/2016. The policy now includes the current State Fire Marshal's contact information in the event that fire sprinkler is out of service for more than 4 hours in a 24 hour day. Person responsible: Paul Charon, Director Building & Grounds Jeff Brown, VP of LTC & Ancillary Services has verified Fire Protection Out of Service Policy (Sprinkler & Alarm Systems), PLA-0008, is complete and acceptable as of August 3, 2016.	7/20/16

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Electronically delivered
July 28, 2016

Mr. Jeff Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, Minnesota 55720

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5045026

Dear Mr. Brown:

The above facility was surveyed on July 11, 2016 through July 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Teresa Ament at (218) 302-6151 or meail: teresa.ament@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00048	A. BUILDING: _____ B. WING _____	07/14/2016

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SUNNYSIDE HEALTH CARE CENTER	512 SKYLINE BOULEVARD CLOQUET, MN 55720

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/11/16 through 7/14/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1/2 sheet pans were free of baked-on debris and a canister of slivered almonds was stored in a sanitary manner. This had the potential to affect all 43 residents in the facility. Findings include: On 7/11/16, at 12:06 p.m. a canister of slivered almonds was observed with a plastic cup used by staff to "scoop" the almonds out of the canister, stored inside it. The nutrition services manager (NSM)-C confirmed that the plastic cup should not be stored in the canister of almonds. On 7/11/16, at approximately 12:15 p.m. four 1/2 sheet pans were observed to have dark, baked-on debris on their inside edges and bottoms. On 7/13/16, at 11:18 a.m. a plastic cup was again observed to be in the canister of slivered	21015	The orders have been reviewed and corrected effective 08/17/2016.	8/17/16

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21015	Continued From page 3 almonds. NSM-C confirmed the scoop was in the canister and that she would remove the canister. On 7/13/16, at 11:19 a.m. 6 1/2 sheets were observed to have baked on food debris on their inside edges sides and bottoms. The debris could not be scraped off. NSM-C stated parchment paper was sometimes used as a pan liner, but it is each cook's preference, not a kitchen protocol. On 7/14/16, at 3:31 p.m. NSM-C stated the 1/2 sheets were specially cleaned. The 1/2 sheets were observed to still have baked on debris. NSM-C stated the 1/2 sheets were used several different ways: they were used to cook meat; they were used to hold desserts in a freezer or cooler; and they were also used as drip pans (placed under the grill to catch juice from cooking meat). NSM-C thought that was why they were soiled. NSM-C confirmed that the debris did not come off and all residents of the nursing home could potentially be served food that had been cooked on the 1/2 sheets. The facility policy Use and Sanitation of Dietary Equipment and Supplies dated 9/20/15, directed employees to notify the dietary manager of all damaged or defective equipment. SUGGESTED METHOD OF CORRECTION: The food service director or designee could review any policies, procedures or facility processes to ensure safe and sanitary food service and make any necessary revisions. Appropriate staff could be educated regarding any changes. The food service director or designee could develop audits to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21015		

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21015	Continued From page 4 (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene was performed during and after	21390	The orders have been reviewed and corrected effective 08/10/2016.	8/10/16

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21390	Continued From page 5 resident cares for 1 of 4 residents (R20) observed during cares. In addition, scissors were not cleaned or replaced after becoming contaminated for 1 of 1 (R55) residents observed during a dressing change. Findings include: R20's Cumulative Diagnosis List dated 1/22/16, indicated R20's diagnoses included congestive heart failure, pleural effusion, atrial fibrillation and venous stasis lung mass. The significant change Minimum Data Set (MDS) dated 4/28/16, indicated R20 had no cognitive impairment. R20 needed extensive assistance of one staff with all activities of daily living (ADL). On 7/13/16, at 9:05 a.m. nursing assistant (NA)-A was assisting R20 with morning cares. The upper portion of R20's cares had already been completed. NA-A washed her hands and donned gloves. R20 stood up from the toilet, NA-A washed R20's peri area and then changed her gloves. NA-A did not wash or sanitize her hands. NA-A then washed R20's buttocks, removed her gloves, pulled up R20's incontinent product and pants. NA-A did not wash or sanitize her hands. NA-A retrieved the walker and R20 ambulated to the recliner. NA-A combed R20's hair, attached the call light to the recliner, moved and set up the over bed table. NA-A retrieved R20's glasses from the bathroom and applied the glasses to R20's face. NA-A moved R20's walker and donned gloves. NA-A did not wash or sanitize her hands. NA-A gathered the bags of trash and soiled linens and put R20's bed clothes in the closet. NA-A removed the gloves, placed both hands on the arm of the recliner, moved the tray table, picked up the soiled linen and trash bags	21390		

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21390	Continued From page 6	21390		

and exited R20's room. NA-A did not wash or sanitize her hands. NA-A walked to the soiled utility room, opened the door with the door knob, put the trash and soiled lined bags in the bins and then washed her hands.

On 7/13/16, at 9:20 a.m. NA-A stated that was the way she usually did cares. NA-A verified she washed her hands in the beginning and did not wash or sanitize her hands between glove changes or prior to exiting R20's room. NA-A stated she should have washed her hands before exiting the room.

On 7/14/16, at 12:45 p.m. the director of nursing (DON) stated staff should be washing or sanitizing their hands between glove changes as able and prior to exiting the resident's room. The DON stated she had talked to staff about hand hygiene constantly and they were all aware.

The facility's Hand Hygiene policy reviewed and revised on 6/18/15, indicated hand hygiene was to be done before and after resident contact and before and after removing any type of glove used in resident cares.

R55's Summary List identified diagnoses that included non-pressure chronic ulcer on the right foot. R55's care plan dated 6/30/16, indicated R55 was admitted with posterior calf ulcers and right foot ulcers. The physician's orders signed 7/6/16, directed Santyl to posterior calf wound twice daily, and bilateral Unn boots.

On 7/13/16, at 9:24 a.m. registered nurse (RN)-B and RN-C were observed preparing to change dressings on R55's lower legs. RN-B stated she would remove the dressings with a blunt scissors.

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21390	Continued From page 7 With the blunt scissors, RN-B cut away the Unna-FLEX dressing (compression dressing) and the underlying Kerlix dressing from R55's left leg, starting near the knee, down to her ankle, and then on top of her foot until both layers of dressing were removed. This was repeated on R55's right leg. As she removed the dressings, RN-B placed them in the garbage on the floor beneath her. RN-B set the scissors down on the towel that was below R55's left leg. The scissors remained on the towel while RN-B and RN-C washed R55's left leg, cleansed the wound on her posterior calf, applied Santyl (an ointment that helps cleanse wounds), and reapplied new Kerlix. RN-C set the scissors down on R55's incontinence pad while she worked to loosen the end of the Unna-FLEX. RN-C then applied the Unna-FLEX dressing to R55's left leg. When finished with R55's left leg, RN-C and RN-B set up a dry washcloth near R55's right leg and placed supplies, including the blunt scissors, on the washcloth and a fresh towel under R55's right leg. RN-C washed R55's right leg, used saline to wash her wound, and applied the Santyl. During this time, the scissors were on R55's blanket, not the clean washcloth. RN-B left the room to get tape and additional Kerlix. Upon her return, RN-B picked up the scissors from R55's blanket and used the scissors to cut tape, which RN-C applied to better hold the Unna-FLEX on R55's left leg. RN-C applied gauze to an additional wound on R55's 4th toe on her right foot. RN-B used the scissors to cut tape that RN-C then used to hold the dressing onto R55's skin.	21390		

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21390	Continued From page 8 On 7/13/16, at 10:08 a.m., RN-B stated that scissors are sanitized after dressing changes by soaking in alcohol in the utility room. In an interview on 7/14/15, at approximately 2:00 p.m., the director of nursing (DON) stated she did not think it was a concern that the scissors did not remain in the clean field, as they were not used against R55's skin after they were off the clean field. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures are maintained. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		8/3/16

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21426	Continued From page 9 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 employees (E)-P had a second step Mantoux read, interpreted and recorded. In addition, the facility failed to ensure 1 of 5 residents (R13) had first and second step Mantoux at admission to the facility. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline tuberculosis (TB) screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. E-P's first step Tuberculin Skin Test (TST, a screening test for tuberculosis) was administered on 5/24/16, and read on 5/26/16, as 0 mm, negative. E-P's second step was administered on 6/13/16, and E-P's employee file lacked documentation of the results. R13 was admitted on 3/17/16. R13's medical	21426	The orders have been reviewed and corrected effective 08/03/2016.	

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21426	Continued From page 10 record lacked documentation of a first or second step Mantoux upon admission. In an interview on 7/14/16, at 11:37 a.m.. registered nurse (RN)-A confirmed R13's two step mantoux was not done upon admission to the facility, nor was she able to obtain documentation that is was done at the assisted living where R13 resided just prior to her admission to the facility. The facility's Mantoux Test Screening, Administration and Reading for Residents policy dated 9/15, indicated screening of new admissions or readmissions for TB would be in compliance with state regulations. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents are screened for physical signs and symptoms of active TB disease on admission. The DON or designee could educate the appropriate staff on the policies/procedures, and could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		8/23/16

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21665	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 10 resident rooms (rooms 254, 260, 262, 264, 265, 267, 270, 271, 272) were well maintained, 3 resident bathroom floors (rooms 269, 270, 271) were clean, and 1 resident wheelchair was in good repair. Findings include: On 7/11/16, at approximately 6:00 p.m., the bathroom floors of rooms 256, 264, and 269 were observed to have a build up of dust and debris in the corners behind the door and under the sink On 7/14/16, at 9:58 a.m. an environmental tour was conducted with the director of building and grounds (DBG) and the environmental services supervisor (ESS). The following rooms were identified in need of repair: Room 254 had long scrapes along the wall. Room 260 had scrapes on two walls. Room 262's door had chipped edges, with sharp, exposed rough wood, approximately 3 feet long. Room 264's door had several chipped areas on the inner and outer edges, approximately 3 feet up from the floor. The door also had plastic covering that was lifted away from the lower outer edge and broken. In addition, the outside of the door had 5 areas of sticky white tape adhesive. The bathroom door, had several chipped areas on the inner and outer edges, approximately 2	21665	The orders have been reviewed and corrected effective 08/23/2016.	

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feet up from the floor. The bathroom door frame had paint scraped off, approximately 2 feet up from the floor.

Room 265's base board had a 2 inch by 2 inch piece missing in the corner between the entry door and the bathroom door, exposing sheetrock.

Room 267's room door was chipped and loose on the inside bottom, approximately 8 inches long. The bathroom door had chips in 3 or 4 areas approximately 3 inches by 1/2 inch. The inner edge of the door also had a 4 inch chipped area. The molding in the corner between the room door and the bathroom had a piece missing, approximately 4 inches by 4 inches, exposing sheet rock. The foot pedal for the bathroom sprayer was tied up with a piece of plastic.

Room 269's bathroom door frame was scraped and peeling.

Room 270's and room 271's entry and bathroom doors were scraped and chipped.

Room 272's entrance door had multiple scuffs on the lower half. The bathroom door was chipped on the outer edge.

R20's wheelchair back had several cracks areas, the left arm rest cover had a small v-shaped crack and 3 small areas with pieces missing. The right arm rest cover had a piece missing approximately 1/2 inch by 1/2 inch. The DSM stated they do not routinely check wheelchairs, but if a nursing assistant or housekeeper notices, they will repair or replace parts of a wheelchair.

On 7/14/16, at approximately 10:00 a.m. the DBG stated they were not aware of these issues and

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21665	Continued From page 13 the do not have a policy on room maintenance. The DBG provided an email dated 5/12/16, explaining the process of requesting work to be completed, but they do have an official policy. On 7/14/16, at approximately 10:15 a.m. the ESM stated their policy is to mop the bathroom floors daily, but perhaps the grout needs to be deep cleaned or replaced. The facility Daily SHCC Resident Room Cleaning policy dated 12/21/15, was provided. The policy directed daily, each resident room and restroom will be cleaned by housekeeping staff. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		